Form 001 Revised 01/02

State of Utah - Labor Commission
Division of Adjudication
160 East 300 South, 3rd Floor, P.O. Box 146615
Salt Lake City, Utah 84114-6615
Note: PLEASE TYPE OR PRINT IN BLACK INK

APPLICATION FOR HEARING

□ **Industrial Accident Claim**
□ Occupational Disease Claim

(NOTE: Include all supporting documentation when this form filed with the Labor Commission. **Please check the appropriate box above for an industrial accident claim** (a specific date for the injury), or an occupational disease claim (the illness developed over time due to an exposure at work).

** I request to have a **Claims Resolution Conference** scheduled to resolve the issues checked below (#5).
____ Yes ____ No

_____
Applicant

_____
Maiden Name and/or Other Names(s) Used by Employee

vs.

_____
Employer

_____
Employer's Street Address

_____
City, State and Zip Code

_____
Employer's Phone Number

_____
Employer's Workers' Compensation Insurance Carrier

EMPLOYEE ALLEGES AND REQUESTS RESOLUTION CONCERNING THE FOLLOWING UNDER TITLE 34A:

1. I sustained an injury by accident or occupational disease arising out of and in the course of employment with the above named Employer(s) on date(s) _____. 19 ____/20_____ of injury/exposure of occupational disease at the following location: _____

2. The accident/exposure occurred as follows:_____
_____

3. The injuries/illnesses I sustained are: _____
_____

4. The injury/illness caused time off work from_____to_____; and _____
_____

5. **I claim: [Please mark an "X" next to any issue you want an immediate hearing on and attach supporting documentation for each issue marked - see reverse side.]**

A. ___	Medical Expenses	D. ___	Temporary Partial Compensation	G. ___	Travel Expenses
B. ___	Recommended Medical Care	E. ___	Permanent Partial Compensation	H. ___	Interest
C. ___	Temporary Total Compensation	F. ___	Permanent Total Compensation	I. ___	Other (Specify) _____

6. My date of birth is_____. At the time of injury/illness my wage was $_____per_____; and I was working ____ hours per week. Also, I was/was not married and had _____ dependent children under age of 18 when I was injured.

(You must include Form 309, Medical Treatment Provider List, with this application. If you need additional space to provide the information requested on Form 309, you may attach additional pages.)

_____
Date

_____
Printed Name of Attorney for Employee State Bar #

_____
Signature of Attorney for Employee

_____
Street Address for Attorney for Employee

_____(____)_____
City/State/Zip Code Telephone #

_____
Applicant (Employee) (Please Print)

_____
Signature of Employee

_____
Street Address of Employee

_____
City/State/Zip Code of Employee

(____)_____
Employee's Telephone # Social Security #

UNSIGNED OR INCOMPLETE FORMS, AND FORMS NOT INCLUDING EMPLOYEE'S SUPPORTING DOCUMENTATION AND INFORMATION REFERENCED ON THE REVERSE SIDE OF THIS FORM WILL BE FILED, BUT RETURNED FOR COMPLETION IN FULL.

DOCUMENTS WHICH MUST ACCOMPANY THIS FORM

A. **List of all health care providers who treated the worker during the last 15 years, and identify the body part(s) treated, date of treatment, and nature of treatment.**

B. **Copies of medical records summaries or medical documentation supporting claim(s).**

C. **<u>In permanent total disability claims only</u>, include copy of Social Security Award Certificate, Decision of Administrative Law Judge or Appeals Council and/or disability Determination and Transmittal Sheet (Form SSA 831-U:5), if Social Security total disability has been awarded.**

D. **<u>If represented by an attorney</u>, include completed and signed Appointment of Counsel form.**

PERMANENT TOTAL DISABILITY CLAIMS ONLY

A. **Date disability began:**_____

B. **Age when disability began:**_____ **Present Age:**_____

C. **Grade completed in school:**_____

D. **Diplomas/degrees/special education classes:**_____

_____

E. **English language difficulties:**_____

F. **Writing and/or reading difficulties:**_____

_____

G. **Treating physician's opinion regarding employee's ability to return to work:**_____

_____

_____

H. **Social Security Total Disability Award Information: Application Date:**_____; **Award Date:**_____

Current status of pending claim:_____

_____

I. **Vocational rehabilitation efforts:**_____

_____

_____

J. **Names of Employers - Years worked and description of work performed:**_____

_____

_____

_____

_____

_____

_____